

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/30/2025
NAME OF PROVIDER OR SUPPLIER  Vidor Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  470 Moore Dr Vidor, TX 77662	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33460</p> <p>47879</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that all alleged violations involving abuse were reported immediately to the abuse coordinator for immediate intervention for 1 of 4 residents (Resident #1) reviewed for abuse and failed to ensure that all alleged violations involving abuse were reported no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or neglect resulting in serious bodily injury, to the State Survey Agency, for 2 of 15 residents (Resident #4, Resident #6) reviewed for reporting allegations of abuse.</p> <p>1. The facility failed to report a verbal abuse allegation immediately to the Abuse Coordinator. CNA A alleged she witnessed LVN B verbally abuse Resident #1 on 10/22/24 at approximately 8:00 p.m. CNA A immediately reported the verbal abuse incident to ADON C and ADON D on 10/22/2024 at 8:30 p.m. ADON C and ADON D did not report the Verbal Abuse allegation immediately to the Administrator who was the Abuse Coordinator.</p> <p>An Immediate Jeopardy (IJ) was identified on 01/28/2025. The IJ Template was provided to the facility on [DATE] at 5:26 p.m. While the IJ was removed on 01/29/2025 at 5:33 p.m., the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>2. The facility failed to report allegation of abuse to the State Agency within 2 hours when it was reported on 8/22/2024 that Resident #5 hit Resident #4 with a soft plastic urinal.</p> <p>3. The facility failed to report allegations of abuse to the State Agency within 2 hours when it was reported on 07/5/2024 that Resident #6 was verbally abused by CNA F.</p> <p>The failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress.</p> <p>Findings included:</p> <p>1. Record review of the admission record dated 01/29/2025 indicated Resident #1 was admitted on [DATE], she was [AGE] years old with Alzheimer's disease, anxiety, and heart failure.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of quarterly MDS assessment dated [DATE] indicated Resident #1 had a BIMS score of 5 and was cognitively impaired. She was able to make herself understood and understood others. No behaviors were noted. Resident #1 had psychotic disorder, anxiety, and depression. Resident #1 had received medication last 7 days of antipsychotic, antianxiety and antidepressant.</p> <p>During an interview on 01/28/2025 at 8:00 a.m., CNA A said on 10/22/2024 around 8:00 p.m., she found Resident #1 on the floor and asked LVN B to check on Resident #1 and assist her to place Resident #1 back in bed. CNA A said she heard LVN B say loudly to Resident #1 you need to keep your fat ass off the floor, and she did not come to work to throw her back out picking your fat ass off the floor. CNA A said Resident #1 said You should not work here then. CNA A said all of that happened while they were putting the resident back in the bed. CNA A said she stepped between the nurse and the resident and said she had it from there. She said she reported the incident to both ADON C and ADON D, who were in their office on the computers, around 8:30 p.m. CNA A said the ADONs sent her to lunch to cool down and she said she was really upset. She said after that she made her rounds and went home after the shift ended. She said the next day she was asked to write her witness statement on the proper form by the human resource department and the administrator. She said the night before she had written her witness statement on notebook paper.</p> <p>During an interview and observation on 01/28/25 at 9:30 a.m., Resident #1 was lying in her bed, well-groomed with no foul odors noted. She said she did not recall any facility staff cursing at her or mistreating her.</p> <p>Record review of Resident #1's skilled nurses' notes dated 10/22/2024 did not indicate any falls or any concerns.</p> <p>Record Review of Resident #1's medical records did not indicate an incident report or event note was completed the day of the incident, 10/22/2024.</p> <p>Record review of LVN B time sheet indicated she was on duty on 10/22/2024 at 1:37 p.m. to 10:10 p.m. and was on duty on 10/23/2024 from 2:00 p.m. to 4:28 p.m.</p> <p>Record review of a weekly skin assessment dated [DATE] indicated LVN B performed a skin assessment on Resident #1 after the incident was reported to the ADONs on 10/22/2024.</p> <p>During an interview on 01/28/2025 at 8:25 a.m., the Administrator said the allegation of LVN B verbally abusing Resident #1 was not reported to him until 10/23/2024. He said he was made aware of the allegation on 10/23/2024 around 4:00 p.m. and reported to the state thereafter. He said all abuse allegations must be reported to him or designee immediately and reported to the state within 2 hours of the allegation. He said residents were at risk of continued abuse if allegations of abuse were not reported as required.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/28/2025 at 9:05 a.m., ADON C said she thought about it more and remembered CNA A had reported to herself and ADON D an allegation of LVN B telling Resident #1 to keep her fat ass off the floor. ADON C said they sent CNA A to go on lunch break. ADON C said they both went to the halls, and she checked on another matter and ADON D went to check on Resident #1. ADON C said herself and ADON D were both working that evening on the halls, and both were responsible for reporting to the Administer/Abuse Coordinator. She stated I thought ADON D had reported the event to the Administer because he was the Abuse Coordinator. She said residents were at risk of continued abuse if allegations of abuse were not reported as required.</p> <p>During an interview and record review on 01/28/2025 at 2:03 p.m., the Administrator said he was not notified of the verbal incident with Resident #1 on 10/22/2024. The State Surveyor reviewed CNA A's witness statement dated 10/23/2024 with the Administrator and identified that the CNA had notified ADON C and ADON D regarding the incident. He said he had not seen that CNA A had reported this allegation to the ADONs on 10/22/2024 when he read CNA A's witness statement originally. He said he had not seen the last sentence about CNA A indicating she reported this event to the ADONs until now. He said the ADONs should have called him immediately and LVN B should have been suspended until the investigation was completed. He said LVN B was suspended on 10/23/2024 at 4:30 p.m. He said the ADONs should have been interviewed during the investigation and disciplined for not reporting the incident immediately.</p> <p>During an interview on 1/28/2025 at 2:37 p.m., ADON D denied that CNA A reported the allegation of LVN B verbally abusing Resident #1 to her. She said she knew the Administrator was investigating the allegation. She said she and ADON C worked that night (10/22/2024), but no one had reported abuse to her, or she would have called the Administrator immediately.</p> <p>Record review on LVN B's personnel file indicated her date of hire was 09/19/2024 and last day worked was 10/23/2024. LVN B was terminated on 10/25/2024 for misconduct.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 01/28/2025 at 5:26 p.m. The facility's Administrator, the ADO, and the Regional Compliance Nurses were notified. The Administrator was provided with the IJ template on 01/28/2025 at 5:26 p.m.</p> <p>The following POR was accepted on 01/29/2025 at 9:53 a.m.:</p> <p>Interventions</p> <p>1.Resident #1 was assessed for emotional distress by the DON on 01/28/2025. A trauma informed care assessment was completed on 01/28/2025 by the DON. No additional emotional distress was noted.</p> <p>2.LVN B was terminated on 10/25/2024 and ADON D resigned. Both are no longer employed at the facility as of 01/28/2025.</p> <p>3.The Administrator, DON, and ADON C were in-serviced 1:1 by the Area Director of Operations and Regional Compliance Nurse on following topics below. Completed on 01/28/2025.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>a. Abuse and Neglect- The administrator is the Abuse Coordinator. Inservice includes that abuse and neglect should be reported immediately to the abuse coordinator. The Abuse coordinator will immediately suspend all alleged perpetrators. Staff named in the allegation(s) are not allowed to continue working. The abuse coordinator will report to HHS immediately but no later than two hours after the event. The abuse coordinator will thoroughly investigate the allegation. The abuse coordinator will delegate responsibilities to start the investigation in the event he is not available. In the event the Administrator can't be reached, the DON will be notified immediately. The alleged perpetrator will not return to work until approved by the abuse coordinator.</p> <p>4.The medical director was informed of the immediate jeopardy citation on 01/28/2025 by DON.</p> <p>5.An ADHOC QAPI meeting was held on 01/28/2025 to include the interdisciplinary team and medical director to discuss the immediate jeopardy citation and plan of removal.</p> <p>In-services:</p> <p>On 01/28/2025, All staff will be in-serviced on the following topics below by the Administrator, Regional Compliance Nurse, DON, and ADON. All staff not present will not be allowed to assume their duties until in-serviced. All PRN staff will be in-serviced prior to their next assignments. All new hires will be in-serviced on their date of hire, during facility orientation. All agency staff will be in-serviced prior to the start of their assignment. Completion date 01/29/2025.</p> <p>a. Abuse and Neglect- The administrator is the Abuse Coordinator. Inservice includes that abuse and neglect should be reported immediately to the abuse coordinator. The Abuse coordinator will immediately suspend all alleged perpetrators. Staff named in the allegation(s) are not allowed to continue working. The abuse coordinator will report to HHS immediately but no later than two hours after the event. The abuse coordinator will thoroughly investigate the allegation. The abuse coordinator will delegate responsibilities to start the investigation in the event he is not available. In the event the Administrator cannot be reached, the DON will be notified immediately. The alleged perpetrator will not return to work until approved by the abuse coordinator.</p> <p>The surveyors monitored the POR on 01/29/2025 as followed:</p> <p>During interviews on 01/29/2025 from 10:00 a.m. - 2:00 p.m. 8 CNAs (CNA GG, CNA II, CNA LL, CNA NN, CNA OO, CNA SS, CNA YY, and CNA DDD), 4 LVN's (LVN E, LVN HH, LVN QQ, and ADON C), 1 LVN/treatment nurse (LVN/Treatment AAA), 1 MA (MA HHH), 2 MDS Nurses ( MDS JJ and MDS KK), 2 Laundry staff (Laundry CC and Laundry GGG), 3 Dietary staff ( Dietary EE, Dietary EEE, and Dietary FFF), 2 Housekeeping staff (HSK RR and HSK CCC), 2 Activities staff (Activities TT and Activities Asst VV), 2 Physical Therapists (PT MM and PT WW), 1 Speech Therapist (ST FF), 1 Certified Occupational therapist assistant (COTA BBB), 1 Business office staff (BO DD), 1 Admission Clerk (Admission ZZ), 1 Human Resource staff (HR XX), 1 Medical Records (MR UU), 1 Maintenance Supervisory (Maintenance PP) (from the A.M. shift) all said they were in-serviced before starting their shift on 01/29/2025 and then given questionnaires to complete to verify their knowledge. All were able to state that their abuse coordinator was the Administrator, and if he was not available, they were to notify the DON. They were all able to give examples of physical, verbal, and emotional abuse. All expressed the importance of reporting alleged abuse immediately when they first saw or heard it. All knew where the corporate compliance hotline number was posted and knew when to contact if needed.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During interviews on 01/29/2024 from 3:55p.m.- 4:20p.m. with 6 alert and oriented residents indicated they recently had communication with management regarding their satisfaction with living at the facility and they had no concerns about their safety, about the staff who provided their daily care, or the management at the facility.</p> <p>During interviews on 01/29/2025 from 2:30p.m. -5:20 p.m. 8 CNAs (CNA LLL, CNA MMM, CNA NNN, CNA OOO, CNA QQQ, CNA RRR, CNA SSS, and CNA TTT), 3 LVNs (LVN III, LVN KKK, and LVN PPP), and 1 MA (MA JJJ) (from 2 p.m.-10 p.m. and 10 p.m. - 6 a.m. shifts) all said they were in-serviced before starting their shift on 01/28/2025 and 1/29/2025 and then given questionnaires to complete to verify their knowledge. All were able to state that their abuse coordinator was the Administrator, if he were not available, they were to notify the DON. They were all able to give examples of physical, verbal, and emotional abuse. All expressed the importance of reporting alleged abuse immediately when they first saw or heard it. All knew where the corporate compliance hotline number was posted and knew when to contact if needed.</p> <p>During an interview on 01/29/2025 at 12:15 p.m., ADON C said she was given one-on-one in-service with the ADO (Area Director of Operations) and the Regional Compliance Nurses regarding reporting alleged abuse to the abuse coordinator immediately (if abuse coordinator was not available or was unreachable, then they would report to the DON ), the timeliness of reporting alleged abuse to HHSC (within 2 hours of the alleged abuse), keeping residents safe, prevention of abuse, and she was to begin investigating alleged allegations immediately if delegated by the abuse coordinator or the DON to do so. She said the alleged perpetrator would be suspended immediately and would not be able to return to work until approval was granted.</p> <p>During an interview on 01/29/2025 at 12:45 p.m., the DON said she was given one-on-one in-service with the ADO (Area Director of Operations) and the Regional Compliance Nurses regarding reporting alleged abuse allegations to the abuse coordinator immediately (if abuse coordinator was not available or was unreachable, then staff would report to her), the timeliness of reporting alleged abuse to HHSC (within 2 hours of the alleged abuse), keeping residents safe, prevention of abuse, and she was to begin investigating alleged allegations immediately if delegated by the abuse coordinator do so. She said if abuse was reported to her in the absence of the abuse coordinator that she would report the alleged allegation to HHSC within 2 hours of the alleged incident. She said the alleged perpetrator would be suspended immediately and would not be able to return to work until approval was granted.</p> <p>During an Interview on 01/29/2025 at 1:00 p.m., the Administrator said he was in-serviced one-on-one with the ADO (Area Director of Operations) and the Regional Compliance Nurses regarding the timeliness of reporting alleged abuse to HHSC (within 2 hours of the alleged abuse), keeping residents safe, prevention of abuse, and that he was to begin investigating alleged allegations immediately and if he was not available, he was to delegate investigation responsibilities to the DON and/or management staff. He said the alleged perpetrator would be suspended immediately and would not be able to return to work until approval was granted. The Administrator said 95% of the active employees had been in-serviced and the remaining employees would be in-serviced before the start of their next shift. The Administrator said all new hires would receive training on abuse, neglect, and timely reporting prior to providing any resident care.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record Review of Resident #1's chart included the Trauma Informed PRN Assessment which was completed on 01/28/2025 at 6:49 p.m. and indicated Resident: #1 did not have any major trauma since she was young.</p> <p>The Administrator, the ADO, and the Regional Compliance Nurses were informed the Immediate Jeopardy was removed on 01/29/2025 at 5:33 p.m. The facility remained out of compliance at a severity level of potential for more than minimal harm, that was not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p> <p>2. Record review of Resident #4's Admission Record dated 01/27/2025 indicated he was a [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses which included intracranial injury with loss of consciousness of unspecified duration (injury to the brain caused by an external force such as a violent blow to the head, resulting in loss of consciousness), aphasia (inability to understand or produce speech, as a result of brain disease or damage), dysphagia (difficulty swallowing), hemiplegia (paralysis of one side of the body), muscle weakness, abnormal gait and mobility, protein malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), and depression (mental illness that negatively affects how you feel, the way you think and how you act).</p> <p>Record review of Resident #4's admission MDS assessment, dated 08/25/2024, indicated a BIMS score of 03 which indicated he was severely impaired cognitively and he was sometimes able to make himself understood and sometimes understood others. He was always incontinent of bowel and bladder. The Functional Status reflected he required total assistance with his ADLs. Resident #1's Mobility Assessment reflected he required total assistance with chair/bed transfers.</p> <p>Record review of Resident #4's care plan, dated 05/15/2024, indicated he had a communication problem related to traumatic brain injury and he was the receiver of physical behaviors. Interventions included demonstrate effective coping skills, evaluation, general assessment, cognitive assessment, trauma informed care assessment, room change, skin assessment, and pain assessment.</p> <p>Record review of Resident #4's event nurses' note authored by DON J (the previous DON) indicated on 08/22/2024 at 9:46 p.m., Event location: Resident Room, Description of the event: Resident was being hit with urinal by roommate. Resident statement related to event: Resident unaware of situation. Intervention: Resident moved to another room. Reportable to state.</p> <p>Unable to interview Resident #4 as he no longer resided at the facility.</p> <p>Record review of Resident #5's Admission Record dated 01/27/2025 indicated he was a [AGE] year-old male initially admitted to the facility on [DATE] with diagnoses which included Gastro-Esophageal Reflux Disease/GERD (stomach contents leak backward from the stomach into the esophagus (food pipe)), blindness one eye and low vision in other eye, diabetes (chronic condition in which the pancreas produces little or no insulin), cerebral ischemia (condition that occurs when there isn't enough blood flow to the brain to meet metabolic demand), and personal history of malignant neoplasm of skin.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #5's quarterly MDS, dated [DATE], indicated a BIMS score of 13 which indicated he was cognitively intact and was able to make himself understood and usually understood others. He was always continent of bowel and bladder. Functional Status reflected he required supervision or touching assistance with his IADL/ADLs except eating and oral care required setup or clean-up assistance.</p> <p>Record review of Resident #5's care plan, dated 08/22/2024, indicated he had demonstrated physical behaviors. He had interventions for staff to analyze of key times, places, circumstances, triggers, and what de-escalates, assess and address for contributing sensory deficits, assess and anticipate resident's needs: food, thirst, Toileting needs, comfort level, body positioning, pain etc. He had interventions for communication: provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated, intervene to protect the residents involved and call for assistance and if intervening would be unsafe, call out for staff assistance immediately, and when the resident becomes agitated: intervene before agitation escalates; Guide away from source of distress; engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Notify the charge nurse of any physically abusive behaviors. Monitor/ document/report to MD of danger to self and others.</p> <p>Record review of Resident #5's event nurses' note authored by DON J indicated on 08/22/2024 at 8:28 p.m., Event location: Resident Room, Description of the event: Nurse reported that CNA reported Resident was seen on the side of his roommate's bed hitting him with urinal. Intervention: Stat labs and Psych consult ordered.</p> <p>Record review of the Provider Investigation Report dated 08/30/2024 indicated on 08/22/2024 at 8:45 p.m., A CNA witnessed Resident #5 hitting Resident #4 with a bedside urinal. The Agency's Immediate Response indicated the residents were separated and neurological checks were started on Resident #4. Skin assessments and monitoring were ordered for both residents. The medical director and the residents' families were notified. Labs were drawn on Resident #5. The Social Worker was notified, and interviews were performed on the residents. Trauma informed care was provided. Staff were in-serviced on abuse, neglect, resident rights, and timely reporting. The Investigation Summary indicated there were no injuries noted to either resident. The Social Worker interviewed Resident #5, in which he confessed that he thought someone was in his bed and upon trying to wake them up he heard what he thought was a growling noise. Resident #5 was almost completely blind, and his roommate Resident #4, spoke in a low audible voice that could be misinterpreted as a growl. After the incident, Resident #5 asked if his roommate was OK and that if he would have realized it was his roommate, he would not have hit him. Resident #5 had no other behaviors or outburst since this occurrence. The Investigation Findings indicated it was inconclusive. The Agency Action Post-Investigation included room changes made would remain permanent, psych evaluations performed for both residents, trauma informed care given, and in-service performed on all staff on abuse and neglect, resident rights, and timely reporting. The date and time reported to HHSC was on 08/23/2024 at 8:50 a.m. (12 hours after the incident was initially reported).</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/27/2025 at 2:15 p.m., Resident #5 said on 08/22/2024 around 8:40 p.m. he was up in the bathroom emptying his urinal and when he was returning to get in bed, he saw something moving in his bed and heard a growling sound, so he swatted at the object with his plastic urinal. Resident #5 said a CNA entered the room and then a nurse came in the room and explained to him that was not his bed and that was his roommate in the bed. Resident #5 said that staff checked him out, did labs, and monitored him after the incident. Resident #5 said he has poor vision and got turned around in the room and was trying to get in the wrong bed and when he heard the growling noise he swatted at the object. Resident #5 said he had requested to be moved to the opposite side of the room prior to incident and must have forgot when he was returning to bed. Resident #5 said he was upset about hitting his roommate (Resident #4) and did not intentionally harm him, he was just defending himself from the growling object.</p> <p>During an interview on 01/27/2025 at 4:51 p.m. ADON C said on 08/22/2024 she was the charge nurse for Hall 100 and around 8:45 p.m., the CNA reported to her that she witnessed Resident #5 hit Resident #4 with a soft plastic urinal. ADON C said she and the CNA separated the residents and verified all residents involved in the incident were safe and reported the incident to the active DON (DON J) and was directed to start the resident-to-resident altercation protocol. ADON C said she immediately reported the incident to the DON and thought the DON would report the incident to the abuse coordinator.</p> <p>During an interview on 01/28/2025 at 10:15 a.m., the Administrator said he was the abuse coordinator and he investigated or designated staff to investigate allegations of abuse or neglect with serious body injury. The Administrator said he was aware that all abuse or neglect allegations with serious bodily injury must be reported to the state within 2 hours of the alleged incident. The Administrator said he reported abuse allegations within 2 hours of him being notified. He said they provided in-services to all the facility staff regarding timely reporting when he identified that the staff were not reporting the incidents timely when he first took the administrator/abuse coordinator role back on 07/30/2024. He said residents were at risk of continued abuse if allegations of abuse were not reported as required.</p> <p>3. Record review of Resident #6's Admission Record dated 01/27/2025 indicated she was an [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses including encephalopathy (disease in which the functioning of the brain is affected by some agent or condition), diabetes (chronic condition in which the pancreas produces little or no insulin), protein malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), and depression (mental illness that negatively affects how you feel, the way you think and how you act).</p> <p>Record review of Resident #6's admission MDS assessment, dated 06/17/2024, indicated a BIMS score of 10 which indicated she was moderately impaired cognitively and she was able to make herself understood and sometimes understood others. She was always incontinent of bowel and bladder. The Functional Status indicated she required set up or clean-up assistance with her IADL/ADLs except eating which she was independent. The Mobility Status indicated she required maximum to moderate assistance with bed mobility, transfers, and ambulation. She used a manual wheelchair for mobility.</p> <p>Record review of Resident #6's care plan, dated 01/31/2024, indicated she had a communication problem related to encephalopathy. The interventions included staff were to anticipate and meet the resident's needs and to monitor for/record confounding problems.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #6's event nurses' note authored by DON J indicated on 07/06/2024 at 2:41 p.m., Event location: Nurses station, Description of the event: CNA F at nurses' station was rude to Resident #6 when she came to nurses' station to request assistance. Allegation reported to DON and administrator. Other information: Reported to state.</p> <p>Record review of Resident #6's weekly skin assessment, dated 07/06/2024 indicated no new skin impairments found during skin assessment.</p> <p>Record review of Resident #6's weekly skin assessment, dated 07/09/2024 indicated no new skin impairments found during assessment.</p> <p>Record review of the Provider Investigation Report dated 07/12/2024 indicated on 07/05/2024 at 10:00 p.m., A CNA spoke rudely to Resident #6 when she requested to be changed. The Agency's Immediate Response indicated the CNA was suspended and Resident #6 was assessed with no injuries. Resident #6 was assisted back to bed and was provided care by assigned CNAs and CN. The Investigation Findings indicated Resident #6 had been very happy about the care she received, except the night of 07/05/2024 when CNA F was rude to her. Facility staff intervened during the incident and removed Resident #6 from the situation and took her back to her room and provided requested care. The Agency Action Post-Investigation included trauma informed care given, and in-service performed on all staff on abuse and neglect. The date and time reported to HHSC was on 07/06/2024 at 4:30 p.m. (&gt;16 hours after the incident was initially reported).</p> <p>Record review of timesheets for facility staff working 07/04/2024 and 07/05/2024 did not indicate CNA F clocked in or worked on 07/05/2024.</p> <p>Unable to interview Resident #6 as she no longer resides at the facility.</p> <p>During an interview on 01/27/2025 at 4:55 p.m., ADON C said on 07/05/2024 she was the outgoing charge nurse for Hall 100 and around 10:00 p.m., she heard CNA F speak rudely to Resident #6 regarding her call light not being on because the call system was not working. ADON C said she intervened, and she and Resident #6's assigned CNA assisted Resident #6 back to her room and provided the requested care. ADON C said that she verified that Resident #6 was safe, and no injuries or distress were noted during providing care and she reported the incident to the oncoming CN and the active DON (DON J). She said residents were at risk of continued abuse if allegations of abuse were not reported as required.</p> <p>Attempted to call DON J on 01/27/2025 at 4:50 p.m. and 5:50 p.m. via telephone for interview, unsuccessful with no answer or returned call.</p> <p>During an interview on 01/28/2025 at 10:15 a.m., the Administrator said he was the abuse coordinator and he investigated or designated staff to investigate allegations of abuse. The Administrator said he was aware that all abuse allegations must be reported to the state within 2 hours of the alleged incident. The Administrator said he reported abuse allegations within 2 hours of him being notified. He said they provided in-services to all the facility staff regarding timely reporting when he identified that the staff were not reporting the incidents timely when he first took the administrator/abuse coordinator role back on 07/30/2024. He said residents were at risk of continued abuse if allegations of abuse were not reported as required.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy Abuse/Neglect, date revised 09/09/2024, indicated .Reporting 1. Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services. State law mandates that citizens report all suspected cases of abuse, neglect, or financial exploitation of the elderly and incapacitated persons. 2. When a suspected abused, neglected, exploited, mistreated or potential victim of misappropriation of property comes to the attention of any employee, that employee will make an immediate verbal report to the Abuse Preventionist or designee. If the discovery occurs outside of normal business hours, the Abuse Preventionist and/or designee will be called. 3. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 2024-14 dated 8/29/2024. a. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation b. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation.</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33460</p> <p>47879</p> <p>Based on observations, interviews, and record review, the facility failed to have evidence that all alleged violations were thoroughly investigated and/or prevent further potential abuse for 1 of 4 resident (Resident #1) reviewed for abuse and neglect.</p> <p>The facility failed to conduct a thorough investigation when CNA A reported to ADON C and ADON D an allegation of verbal abuse of LVN B to Resident #1 on 10/22/2024 at 8:30 p.m.</p> <p>The facility failed to protect Resident #1 from further alleged/potential verbal abuse by allowing LVN B to work in the facility on 10/22/2024 after the allegation and to work on 10/23/2024 until 4:30 p.m.</p> <p>An Immediate Jeopardy (IJ) was identified on 01/28/2025. The IJ Template was provided to the facility on [DATE] at 5:26 p.m. While the IJ was removed on 01/29/2025 at 5:33 p.m., the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>The failures could place residents at risk of undetected abuse, trauma, and/or decline in feelings of safety and well-being and psychosocial harm.</p> <p>Findings included:</p> <p>1. Record review of the admission record dated 01/29/2025 indicated Resident #1 was admitted on [DATE], she was [AGE] years old with Alzheimer's disease, anxiety, and heart failure.</p> <p>Record review of quarterly MDS assessment dated [DATE] indicated Resident #1 had a BIMS score of 5 and was cognitively impaired. She was able to make herself understood and understood others. No behaviors were noted. Resident #1 had psychotic disorder, anxiety, and depression. Resident #1 had received medication last 7 days of antipsychotic, antianxiety and antidepressant.</p> <p>During an interview on 01/28/2025 at 8:00 a.m., CNA A said on 10/22/2024 around 8:00 p.m., she found Resident #1 on the floor and asked LVN B to check on Resident #1 and assist her to place Resident #1 back in bed. CNA A said she heard LVN B say loudly to Resident #1 you need to keep your fat ass off the floor, and she did not come to work to throw her back out picking your fat ass off the floor. CNA A said Resident #1 said You should not work here then. CNA A said all of that happened while they were putting the resident back in the bed. CNA A said she stepped between the nurse and the resident and said she had it from there. She said she reported the incident to both ADON C and ADON D, who were in their office on the computers, around 8:30 p.m. CNA A said the ADONs sent her to lunch to cool down and she said she was really upset. She said after that she made her rounds and went home after the shift ended. She said the next day she was asked to write her witness statement on the proper form by the human resource department and the administrator. She said the night before she had written her witness statement on notebook paper.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 01/28/25 at 9:30 a.m., Resident #1 was lying in her bed, well-groomed with no foul odors noted. She said she did not recall any facility staff cursing at her or mistreating her.</p> <p>Record review of Resident #1's skilled nurses' notes dated 10/22/2024 did not indicate any falls or any concerns.</p> <p>Record Review of Resident #1's medical records did not indicate an incident report or event note was completed the day of the incident, 10/22/2024.</p> <p>Record review of LVN B time sheet indicated she was on duty on 10/22/2024 at 1:37 p.m. to 10:10 p.m. and was on duty on 10/23/2024 from 2:00 p.m. to 4:28 p.m.</p> <p>Record review of a weekly skin assessment dated [DATE] indicated LVN B performed a skin assessment on Resident #1 after the incident was reported to the ADONs on 10/22/2024.</p> <p>During an interview on 01/28/2025 at 8:25 a.m., the Administrator said the allegation of LVN B verbally abusing Resident #1 was not reported to him until 10/23/2024. He said he was made aware of the allegation on 10/23/2024 around 4:00 p.m. and reported to the state thereafter. He said all abuse allegations must be reported to him or designee immediately and reported to the state within 2 hours of the allegation. He said residents were at risk of continued abuse if allegations of abuse were not reported as required.</p> <p>During an interview on 01/28/2025 at 9:05 a.m., ADON C said she thought about it more and remembered CNA A had reported to herself and ADON D an allegation of LVN B telling Resident #1 to keep her fat ass off the floor. ADON C said they sent CNA A to go on lunch break. ADON C said they both went to the halls, and she checked on another matter and ADON D went to check on Resident #1. ADON C said herself and ADON D were both working that evening on the halls, and both were responsible for reporting to the Administer/Abuse Coordinator. She stated I thought ADON D had reported the event to the Administer because he was the Abuse Coordinator. She said residents were at risk of continued abuse if allegations of abuse were not reported as required. She said that she should have verified that the allegations of abuse were reported to the abuse coordinator immediately. She said not reporting the abuse allegation to the abuse coordinator could delay the investigation of the allegation and place residents at risk for continued abuse.</p> <p>During an interview and record review on 01/28/2025 at 2:03 p.m., the Administrator said he was not notified of the verbal incident with Resident #1 on 10/22/2024. The State Surveyor reviewed CNA A's witness statement dated 10/23/2024 with the Administrator and identified that the CNA had notified ADON C and ADON D regarding the incident. He said he had not seen that CNA A had reported this allegation to the ADONs on 10/22/2024 when he read CNA A's witness statement originally. He said he had not seen the last sentence about CNA A indicating she reported this event to the ADONs until now. He said the ADONs should have called him immediately and LVN B should have been suspended until the investigation was completed. He said LVN B was suspended on 10/23/2024 at 4:30 p.m. He said the ADONs should have been interviewed during the investigation and disciplined for not reporting the incident immediately. He said not investigating the allegation of abuse thoroughly could place the residents at risk for undetected or continued abuse, and/or a decline in feeling safe at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/28/2025 at 2:37 p.m., ADON D denied that CNA A reported the allegation of LVN B verbally abusing Resident #1 to her. She said she knew the Administrator was investigating the allegation. She said she and ADON C worked that night (10/22/2024), but no one had reported abuse to her, or she would have called the Administrator immediately.</p> <p>Record review on LVN B's personnel file indicated her date of hire was 09/19/2024 and last day worked was 10/23/2024. LVN B was terminated on 10/25/2024 for misconduct.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 01/28/2025 at 5:26 p.m. The facility's Administrator, the ADO, and the Regional Compliance Nurses were notified. The Administrator was provided with the IJ template on 01/28/2025 at 5:26 p.m.</p> <p>The following POR was accepted on 01/29/2025 at 9:53 a.m.:</p> <p>Interventions</p> <ol style="list-style-type: none"> <li>1. Resident #1 was assessed for emotional distress by the DON on 01/28/2025. A trauma informed care assessment was completed on 01/28/2025 by the DON. No additional emotional distress was noted.</li> <li>2. LVN B was terminated on 10/25/2024 and ADON D resigned. Both are no longer employed at the facility as of 01/28/2025.</li> <li>3. The Administrator, DON, and ADON C were in-serviced 1:1 by the Area Director of Operations and Regional Compliance Nurse on following topics below. Completed on 01/28/2025.             <ol style="list-style-type: none"> <li>a. Abuse and Neglect- The administrator is the Abuse Coordinator. Inservice includes that abuse and neglect should be reported immediately to the abuse coordinator. The Abuse coordinator will immediately suspend all alleged perpetrators. Staff named in the allegation(s) are not allowed to continue working. The abuse coordinator will report to HHS immediately but no later than two hours after the event. The abuse coordinator will thoroughly investigate the allegation. The abuse coordinator will delegate responsibilities to start the investigation in the event he is not available. In the event the Administrator can't be reached, the DON will be notified immediately. The alleged perpetrator will not return to work until approved by the abuse coordinator.</li> </ol> </li> <li>4. The medical director was informed of the immediate jeopardy citation on 01/28/2025 by DON.</li> <li>5. An ADHOC QAPI meeting was held on 01/28/2025 to include the interdisciplinary team and medical director to discuss the immediate jeopardy citation and plan of removal.</li> </ol> <p>In-services:</p> <p>On 01/28/2025, All staff will be in-serviced on the following topics below by the Administrator, Regional Compliance Nurse, DON, and ADON. All staff not present will not be allowed to assume their duties until in-serviced. All PRN staff will be in-serviced prior to their next assignments. All new hires will be in-serviced on their date of hire, during facility orientation. All agency staff will be in-serviced prior to the start of their assignment. Completion date 01/29/2025.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>a. Abuse and Neglect- The administrator is the Abuse Coordinator. Inservice includes that abuse and neglect should be reported immediately to the abuse coordinator. The Abuse coordinator will immediately suspend all alleged perpetrators. Staff named in the allegation(s) are not allowed to continue working. The abuse coordinator will report to HHS immediately but no later than two hours after the event. The abuse coordinator will thoroughly investigate the allegation. The abuse coordinator will delegate responsibilities to start the investigation in the event he is not available. In the event the Administrator cannot be reached, the DON will be notified immediately. The alleged perpetrator will not return to work until approved by the abuse coordinator.</p> <p>The surveyors monitored the POR on 01/29/2025 as followed:</p> <p>During interviews on 01/29/2025 from 10:00 a.m. - 2:00 p.m. 8 CNAs (CNA GG, CNA II, CNA LL, CNA NN, CNA OO, CNA SS, CNA YY, and CNA DDD), 4 LVN's (LVN E, LVN HH, LVN QQ, and ADON C), 1 LVN/treatment nurse (LVN/Treatment AAA), 1 MA (MA HHH), 2 MDS Nurses ( MDS JJ and MDS KK), 2 Laundry staff (Laundry CC and Laundry GGG), 3 Dietary staff ( Dietary EE, Dietary EEE, and Dietary FFF), 2 Housekeeping staff (HSK RR and HSK CCC), 2 Activities staff (Activities TT and Activities Asst VV), 2 Physical Therapists (PT MM and PT WW), 1 Speech Therapist (ST FF), 1 Certified Occupational therapist assistant (COTA BBB), 1 Business office staff (BO DD), 1 Admission Clerk (Admission ZZ), 1 Human Resource staff (HR XX), 1 Medical Records (MR UU), 1 Maintenance Supervisory (Maintenance PP) (from the A.M. shift) all said they were in-serviced before starting their shift on 01/29/2025 and then given questionnaires to complete to verify their knowledge. All were able to state that their abuse coordinator was the Administrator, and if he was not available, they were to notify the DON. They were all able to give examples of physical, verbal, and emotional abuse. All expressed the importance of reporting alleged abuse immediately when they first saw or heard it. All knew where the corporate compliance hotline number was posted and knew when to contact if needed.</p> <p>During interviews on 01/29/2024 from 3:55p.m.- 4:20p.m. with 6 alert and oriented residents indicated they recently had communication with management regarding their satisfaction with living at the facility and they had no concerns about their safety, about the staff who provided their daily care, or the management at the facility.</p> <p>During interviews on 01/29/2025 from 2:30p.m. -5:20 p.m. 8 CNAs (CNA LLL, CNA MMM, CNA NNN, CNA OOO, CNA QQQ, CNA RRR, CNA SSS, and CNA TTT), 3 LVNs (LVN III, LVN KKK, and LVN PPP), and 1 MA (MA JJJ) (from 2 p.m.-10 p.m. and 10 p.m. - 6 a.m. shifts) all said they were in-serviced before starting their shift on 01/28/2025 and 1/29/2025 and then given questionnaires to complete to verify their knowledge. All were able to state that their abuse coordinator was the Administrator, if he were not available, they were to notify the DON. They were all able to give examples of physical, verbal, and emotional abuse. All expressed the importance of reporting alleged abuse immediately when they first saw or heard it. All knew where the corporate compliance hotline number was posted and knew when to contact if needed.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/29/2025 at 12:15 p.m., ADON C said she was given one-on-one in-service with the ADO (Area Director of Operations) and the Regional Compliance Nurses regarding reporting alleged abuse to the abuse coordinator immediately (if abuse coordinator was not available or was unreachable, then they would report to the DON ), the timeliness of reporting alleged abuse to HHSC (within 2 hours of the alleged abuse), keeping residents safe, prevention of abuse, and she was to begin investigating alleged allegations immediately if delegated by the abuse coordinator or the DON to do so. She said the alleged perpetrator would be suspended immediately and would not be able to return to work until approval was granted.</p> <p>During an interview on 01/29/2025 at 12:45 p.m., the DON said she was given one-on-one in-service with the ADO (Area Director of Operations) and the Regional Compliance Nurses regarding reporting alleged abuse allegations to the abuse coordinator immediately (if abuse coordinator was not available or was unreachable, then staff would report to her), the timeliness of reporting alleged abuse to HHSC (within 2 hours of the alleged abuse), keeping residents safe, prevention of abuse, and she was to begin investigating alleged allegations immediately if delegated by the abuse coordinator do so. She said if abuse was reported to her in the absence of the abuse coordinator that she would report the alleged allegation to HHSC within 2 hours of the alleged incident. She said the alleged perpetrator would be suspended immediately and would not be able to return to work until approval was granted.</p> <p>During an Interview on 01/29/2025 at 1:00 p.m., the Administrator said he was in-serviced one-on-one with the ADO (Area Director of Operations) and the Regional Compliance Nurses regarding the timeliness of reporting alleged abuse to HHSC (within 2 hours of the alleged abuse), keeping residents safe, prevention of abuse, and that he was to begin investigating alleged allegations immediately and if he was not available, he was to delegate investigation responsibilities to the DON and/or management staff. He said the alleged perpetrator would be suspended immediately and would not be able to return to work until approval was granted. The Administrator said 95% of the active employees had been in-serviced and the remaining employees would be in-serviced before the start of their next shift. The Administrator said all new hires would receive training on abuse, neglect, and timely reporting prior to providing any resident care.</p> <p>Record Review of Resident #1's chart included the Trauma Informed PRN Assessment which was completed on 01/28/2025 at 6:49 p.m. and indicated Resident: #1 did not have any major trauma since she was young.</p> <p>Record review of the facility's policy Abuse/Neglect, date revised 09/09/2024, indicated .F. Investigation: Comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventionist. All allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injuries of unknown source will be investigated . 6. The Abuse Preventionist and/or administrator will conduct a thorough investigation of the incident(s). A copy of the written report will accompany any personnel action deemed necessary. If a personnel action occurs, a copy of all pertinent documents will be placed in the employee's personnel file.</p> <p>The Administrator, the ADO, and the Regional Compliance Nurses were informed the Immediate Jeopardy was removed on 01/29/2025 at 5:33 p.m. The facility remained out of compliance at a severity level of potential for more than minimal harm, that was not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33460</p> <p>47879</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident's environment remained free of accident hazards and the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Resident #2) reviewed for accidents and supervision.</p> <p>The facility failed to ensure adequate supervision for Resident #2 with two staff members for bed mobility during pressure ulcer treatment to prevent a fall with injury on 10/29/2024.</p> <p>The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 10/29/24 and ended on 10/29/2024. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk for injury and harm due to the lack of supervision provided by the facility.</p> <p>Findings included:</p> <p>Record review of the face sheet for Resident #2 indicated she was admitted on [DATE], was [AGE] years old with diagnosis of high blood pressure, kidney disease, stroke, and morbid obesity.</p> <p>Record review of the physician orders October 2024 for Resident #2 indicated she had an order for Acetaminophen Tablet 325 mg, give 650 mg by mouth every 4 hours as needed for pain give two 325mg tabs to give 650mg with start date of 11/16/2020.</p> <p>Record review of the MDS state optional assessment dated [DATE] indicated Resident #2 required 2 staff members for bed mobility. Her BIMS indicated severe cognitive impairment with score of 6.</p> <p>Record review of the quarterly MDS assessment dated [DATE] indicated Resident #2 was able to understand and make her needs known. She required substantial/ maximal assistance with the helper doing more than half the effort. Her BIMS indicated severe cognitive impairment with score of 6.</p> <p>Record review of the care plan dated 09/09/2024 indicated Resident #2 had an ADL self-care performance deficit. Resident #2 required 2 staff for assistance with bed mobility, with start date of 11/23/2020.</p> <p>Record review of the Kardex dated 10/22/2024 indicated Resident #2 required 2 staff for bed mobility.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Vidor Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  470 Moore Dr Vidor, TX 77662	
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the nurse progress notes for Resident #2 indicated on 10/29/2024 at 11:00 a.m., LVN H was performing a treatment while Resident #2 was rolled over holding onto the P rail. The resident she rolled off onto the floor. Resident #2 had a small skin tear to her right upper arm and small scratch to her left arm. LVN H cleaned both areas and applied a bandage to the resident's right arm skin tear. LVN H said the resident did not hit her head and the fall was witnessed. She assisted the resident back into the bed with a mechanical lift.</p> <p>Record review of the hospital records dated 10/30/2024 indicated Resident #2 had no fractures or head injuries. Resident #2 did have bruises to the side of the face and to the abdomen and bruises with skin tear on right upper arm. She was transferred back to the facility with no new orders.</p> <p>Record review of the nurse progress notes for Resident #2 indicated on 10/30/2024 at 1:04 a.m., the resident was back in facility after she was sent to the local hospital related to the fall. A CT was done of her head and X-rays were done of her knees and ankles. No fractures or abnormalities shown.</p> <p>Record review of the MAR for October 2024 indicated Resident #2 received 2 doses of Tylenol 325 mg 2 tablets on 10/29/2024 and 10/30/2024 for abdomen pain and it was effective.</p> <p>Record review of an in-service training dated 10/29/2024 indicated LVN H was retrained on bed mobility for Resident #2, the use of Kardex and documenting falls. The training documents indicated where in the Kardex the staff could locate bed mobility and how many staff were required.</p> <p>Record review of an in-service dated 10/29/2024 at 6:30 p.m. indicated nursing staff were retrained on the use of the Kardex system and documenting falls. The training documents indicated where in the Kardex the staff could locate bed mobility and how many staff were required.</p> <p>Record review of the Kardex dated 10/30/2024 indicated Resident #2 required 2 staff for bed mobility.</p> <p>During an interview on 01/27/2025 at 9:05 a.m., Resident #2 said the day she fell , LVN H was doing a treatment with no one helping her. Resident #2 stated I told her she needed someone to help turn me and the nurse said she could not find anyone to help. She stated, the nurse turned me towards my right side, and I fell out of the bed.</p> <p>During an interview on 01/27/2025 at 1:28 p.m., LVN H said she had not been oriented about the Kardex system until after the incident with Resident #2. LVN H said she thought she could do the treatment by herself because she could not find someone who could help her turn the resident. She stated, When I turned the resident towards her right side, she fell off the bed onto the floor. She said the bed was not against the wall and there was a small gap and that was where Resident #2 fell to the floor. LVN H denied the resident told her to get help. She said the resident was assessed for serious injuries and placed back in the bed and then sent to the hospital.</p> <p>During an interview 01/27/2025 at 10:30 a.m., ADON C said she had orientated LVN H when she was hired and told the nurse about the Kardex system. ADON C said all nursing staff were retrained on 10/29/24 following the incident with Resident #2, on the use of the Kardex system and to check how many staff were required for turning, transfer, toileting and eating.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/27/2025 at 10:12 a.m., the DON said LVN H was not terminated due to the incident; however, she had since been terminated. The DON said all the nursing staff were retrained on the Kardex system to ensure all staff knew about the residents who needed 2 staff for bed mobility. The DON said her expectation was for the staff to get help in turning the residents who required 2 staff members per Kardex.</p> <p>Record review of the personnel file record for LVN H indicated she was hired 10/24/2024. She was suspended on 10/29/2024 for the incident involving Resident #2 and after the investigation, she was provided additional training related to the Kardex system. She was terminated on 11/19/24 was for a different reason.</p> <p>During an interview on 01/27/2025 at 10:05 a.m., LVN E said Resident #2 had always been 2 staff with turning her and for her treatment. She said Resident #2 required 2 staff for transfer.</p> <p>During an interview on 01/27/2025 at 11:01 a.m., LVN III said when you reposition Resident #2 must use 2 staff.</p> <p>During an interview on 01/27/2025 at 11:30 a.m., CNA A said she knew to use 2 staff with Resident #2. She said when giving incontinent care or transfer must us 2 staff.</p> <p>During an interview on 01/27/2025 at 11:30 a.m., CNA SS said Resident #2 required 2 for bed mobility and 2 for transfer.</p> <p>During an interview on 01/27/2025 at 11:50 a.m., LVN AAA said Resident #2 required assistance when she performed Resident 2's treatment to hold the resident.</p> <p>She said Resident #2 was unable to balance self on her side.</p> <p>During an observation on 01/27/2025 12:00 p.m., LVN E and CNA A repositioned Resident #2 on her back and pulled her up in the bed to prepare for lunch.</p> <p>During interviews on 01/27/2025 at 1:30 to 4:30 p.m., 8 CNAs (CNA GG, CNA II, CNA LL, CNA NN, CNA OO, CNA SS, CNA YY, and CNA DDD), 4 LVNs (LVN E, LVN HH, LVN QQ, and ADON C), 1 LVN/treatment nurse (LVN/Treatment AAA), 1 MA (MA HHH), 2 MDS Nurses ( MDS JJ and MDS KK), 2 Physical Therapists (PT MM and PT WW), 1 Speech Therapist (ST FF), 1 Certified Occupational therapist assistant (COTA BBB). All the staff were retrained on the Kardex system and said the program indicated how many staff was required for eating, transfer, bed mobility and ambulation.</p> <p>During an interview on 01/27/2025 at 4:30 p.m., the Administrator said he expected the staff to use the Kardex system and get help when help is needed or required.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility policy dated 12/30/2005 titled Safe Patient Handling indicated The facility has a program to promote and assure safe patient handling for both the resident and the employee. The policy includes identification, assessment, and interventions to provide a comfortable, safe transfer, repositioning and resident movement. 1.Nurses will identify residents in need of transfer, repositioning, or movement assistance. 2.Nurses will assess the risks associated with lifting, transferring, repositioning or movement assistance. 3.Nurses will be educated in the identification, assessment, and control of risks of injury to resident and nurses during patient handling. 4.Resident will be evaluated on admission and as needed for alternative means of lifting, transferring, repositioning and other movement to minimize risk of injury.</p> <p>1. Nurses will be educated regarding correct safe handling procedures, to report concerns or the inability to perform resident handling or movement that the nurse believes in good faith will expose a resident or nurse to an unacceptable risk of injury.</p> <p>2. Facility staff will report to supervisor the inability to complete resident lifting, transfer, or repositioning if they feel it will either endanger the resident or cause injury to staff.</p> <p>The undated Comprehensive care plan policy indicated The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Comprehensive care plans may include but are not limited to resident Kardex records, baseline care plans, and task listings.</p> <p>On 02/10/2025 at 10:22 a.m., the Administrator was informed of the Immediate Jeopardy. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 10/29/2024 and ended on 10/29/2024. The facility had corrected the noncompliance before survey began.</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>22183</p> <p>Based on interviews and record review, the facility failed to designate one or more individual(s) as the infection preventionist(s) which had completed specialized training in infection prevention and control for 1 of 1 Infection Preventionist (LVN IC) reviewed for infection control training.</p> <p>The facility's Infection Preventionist did not have specialized infection control training.</p> <p>This failure could affect the facility's ability to appropriately recognize and respond to communicable diseases and infections.</p> <p>Findings included:</p> <p>During an interview on 01/27/2025 at 11:21 a.m., the DON said LVN IC was the Infection Control Preventionist (ICP) and the second ADON for the facility. The DON said she was not sure if LVN IC had completed the certified training.</p> <p>During an interview on 01/28/2025 at 2:12 p.m., LVN IC said she was responsible for the facility's infection control. LVN IC said she started working at the facility in October of 2024 and was hired as an ADON and ICP. She said sometimes she could not get to all her ICP duties because she was working on the floor as a charge nurse. LVN IC said the training she received on November 4th was the DON training with the Corporate Nurse on how to do infection control assessments and had not yet started the specialized infection control training. LVN IC said her not having the specialized infection control training could put the facility at risk of ineffective surveillance of infections.</p> <p>During an interview on 01/28/2025 at 2:45 p.m., LVN E said she was now a charge nurse on the floor and was no longer the infection preventionist since about two to three months ago when the new ICP (LVN IC) took over. She said when she gave her resignation, she was no longer responsible for the role of infection preventionist for the facility. LVN E said she did complete the specialized training as a personal preference for CEUs.</p> <p>During an interview on 01/29/2025 at 3:00 p.m., the DON said LVN IC was the ICP, and she was the back-up ICP, but LVN IC was responsible for the role. The DON said she was new at the facility and had been trained in infection control at the same time as LVN IC's training. The DON said not having a trained ICP could put the facility at risk of ineffective surveillance of infections.</p> <p>During an interview on 01/29/2025 at 3:30 p.m., the Regional Compliance Nurse AA acknowledged the facility was to have a certified individual who was responsible for the infection control program at all times. The Regional Compliance Nurse AA said without an infection control preventionist the facility could miss opportunities to observe infection control practices to ensure they were implemented appropriately and increased the risk of infections going unnoticed. She said both the DON and LVN IC started the training last night (01/28/2025).</p> <p>(continued on next page)</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's infection control policy titled, Infection Control Plan: Overview , dated 03/2024, revealed . Facility IP, DON, and Administrator will complete the CDC train course to provide initial and ongoing education of all healthcare workers in the theory and practice of infection control and prevention .</p>